

**VOLUME VII
SECTION IV**

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1. CASE MANAGEMENT

The case management process is a systematic approach essential to effective service delivery that actively involves the service worker, the adult, and the adult's family in developing, achieving, and maintaining meaningful goals. The purpose of case management in Adult Services is to structure the service worker's focus and activities to assist the adult in reaching his or her goals and to assure that the adult receives appropriate services in a timely manner. See Volume VII, Section I, Chapter B, Intake and Case Management, for additional information.

2. ADULT SERVICES INTAKE

2.1. Basis

Intake services provide an initial access point for services provided by the local department. Upon determining that there is no valid APS report, the worker proceeds with the adult services intake process. The initial contact may be made by telephone, office visit, and/or through a referral from another agency. Services provided may include information and referral, initial screening and assessment, crisis intervention, and assistance with emergency needs if indicated by the care situation or assessment.

2.2. Application for Adult Services

Anyone may apply for services; there shall be no requirement as to citizenship or length of residence in the jurisdiction. The local department must accept all applications. See Volume VII, Section I, Chapter B, Intake and Case Management for additional information on applications. The Service Application may be completed by one of the following:

2.2.1 The applicant;

2.2.2 Someone authorized by the applicant who is acting on behalf of the applicant; or

2.2.3 The local department of social services when the applicant is unable to sign the application or is incapacitated.

If the adult is capable, the worker must discuss the service request with the adult to ensure that the services requested or applied for are desired by the adult. If it is determined that the adult will be eligible for services within 45 days, the beginning date of service authorization is the date the application/request for service is received in the local department.

Telephone calls to the local department are not considered an "application" unless the local department started a department-initiated application.

Service applications are not required for case type "ALF Reassessment" if

the only service provided is the annual reassessment or case type “Guardian Report” if the only service provided is the review of the Annual Report of the Guardian (Note: the Application Date for the Case Info screen in ASAPS would be the date the case information is received in the local department). If additional services are provided beyond the service required for each of these case types, a signed service application must be obtained.

2.3. Determining Eligibility and Opening a Case

The criteria and procedures for determining financial eligibility and need for services, completing the preliminary assessment, and opening a case are addressed in Volume VII, Section I, Chapter B, Intake and Case Management. A service case is opened based on eligibility, determination of need, and the availability and intent to deliver the service. Financial eligibility requirements as designated by local social services boards in local policy must be considered.

2.3.1 An adult who receives Adult Services (e.g., companion, chore, or homemaker services, adult day services, or adult foster care) must fall within one of the target populations and meet one of the following criteria:

- 1) Be 60 years of age or older; or
- 2) Be 18 years of age or older and be impaired.

“Being impaired” means any adult:

WHOSE PHYSICAL OR MENTAL CAPACITY IS DIMINISHED TO THE EXTENT THAT HE NEEDS COUNSELING OR SUPERVISORY ASSISTANCE, OR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADLS) SUCH AS FEEDING, BATHING, AND WALKING OR INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS) SUCH AS SHOPPING AND MONEY MANAGEMENT (22 VAC 40-800-10).

This does not mean that the adult needs to be determined eligible for SSA/SSI disability services or benefits prior to receiving services from the local department of social services.

Adult protective services are provided to incapacitated adults 18 years of age or over and adults 60 years of age or over who are abused, neglected or exploited or at risk of abuse, neglect, or exploitation.

“Incapacitated person” means any adult:

WHO IS IMPAIRED BY REASON OF MENTAL ILLNESS, MENTAL RETARDATION, PHYSICAL ILLNESS OR DISABILITY,

ADVANCED AGE OR OTHER CAUSES TO THE EXTENT THAT HE LACKS SUFFICIENT UNDERSTANDING OR CAPACITY TO MAKE, COMMUNICATE, OR CARRY OUT RESPONSIBLE DECISIONS CONCERNING HIS WELL-BEING (22 VAC 40-800-10).

2.3.2 To open a case to Adult Services, proper procedures must be followed regarding ASAPS and Notice of Action. See the ASAPS User's Manual and Training Guide and Volume VII, Section I, Chapter B, Intake and Case Management, for information. The ASAPS User's Manual and Training Guide may be found online at:
<http://spark.dss.virginia.gov/divisions/dis/asaps/index.cgi>.

2.3.3 The local department must notify the applicant of decisions promptly, but no later than 45 days after the application is received. See Volume VII, Section I, Chapter B, for information on the notification process.

2.3.4 The "Rights and Responsibilities" of the applicant are on the reverse side of the applicant's copy of the services application. During the Intake process, the worker should discuss these rights and responsibilities with the applicant and/or his authorized representative.

2.4. Fraud

Local departments must explain to applicants for Adult Services the importance of providing accurate and thorough information and of notifying the local department of changes during service delivery. Anyone who causes the local department to make an improper vendor payment by withholding information or by providing false information may be required to repay the amount of the improper payment. The *Code of Virginia*, § 63.2-522, deems guilty of larceny, any person who obtains assistance or benefits by means of a willful false statement or who knowingly fails to notify the local department of a change in circumstances that could affect eligibility for assistance. Recipients deemed guilty of larceny, upon conviction, are subject to penalties as specified in the *Code of Virginia*, § 18.2-95

3. ASSESSMENT PROCESS

3.1. Basis

The assessment process is a mutual process between the service worker and the adult that begins at intake. Completing the assessment is the first step in service planning. The purpose of assessment is to determine whether the adult is in need of services, and, if so, to identify what services

are needed. Assessment should take place throughout the entire case management process and is essential to service planning.

When an adult applies for a service, a preliminary assessment shall be made to determine the presenting problem(s) or immediate need(s). The assessment is to continue on a mutual basis between the adult and service worker in order to document further service needs as a basis for the setting of long-range service objectives, the selection of services to fulfill those objectives, and the choices of resources to be used. These activities will be reflected in the completed service plan.

3.2. The Virginia Uniform Assessment Instrument (UAI)

The Virginia Uniform Assessment Instrument (UAI) must be used by public human services agencies in the Commonwealth to assess adult service needs and service eligibility. The definitions used and procedures for completing the UAI are found in the User's Manual: Virginia Uniform Assessment Instrument. The User's Manual may be found online at: <http://spark.dss.virginia.gov/divisions/dfs/as/manual.cgi>. The UAI is located at <http://spark.dss.virginia.gov/divisions/dfs/as/forms.cgi>.

A computerized UAI may be found in ASAPPS as part of the case management process. See the ASAPPS User Manual for details. The UAI in ASAPPS may be printed as needed.

The following are guidelines for use of the UAI in local departments:

- 3.2.1** At a minimum, the following five areas must be addressed in the assessment process: the adult's physical health, psychosocial status, functional abilities, support systems, and physical environment. The UAI provides a format that assesses each area.
- 3.2.2** If, during an assessment, it is determined that the adult is being abused, neglected or exploited or is at risk of being abused, neglected or exploited, an APS report must be completed and APS procedures followed according to Volume VI, Section IV, Chapter B.
- 3.2.3** The UAI must be completed in its entirety for any purchased services including home-based services (companion, chore, and homemaker), adult day services, and adult foster care. When the UAI is completed in its entirety, the worker has met the assessment requirements for the development of the service plan for an Adult Services case. In an Adult Protective Services case, an assessment to determine the need for protective services is required (See Vol. VII, Section IV, Chapter B). If services are provided after the determination of the protective services needs, the entire UAI must be completed.

- 3.2.4** The UAI must be completed in its entirety for nursing facility preadmission screening. For nursing facility preadmission screenings, the Department of Medical Assistance Services will accept a UAI with the initial assessment and only one reassessment.
- 3.2.5** The UAI must be completed for assisted living facility (ALF) assessments per requirements in the *Assisted Living Facility Assessment Manual*.
- 3.2.6** For case types AS – Intensive services and AS (Adult Services) that are NOT purchased services (e.g., assisting with SSI or Social Security issues), the short form of the UAI (pages 1 through 4) must be completed. The worker must ensure that all required assessment areas are addressed.
- 3.2.7** When completing the short form of the UAI, the worker must ensure that all required assessment areas are addressed. The required assessment areas of physical health, psychosocial status, and support systems may be addressed by completing other relevant sections of the UAI, writing a narrative, or completing a local department-approved assessment form that covers the areas not addressed on the short form of the UAI.
- 3.2.8** The UAI must be used for reassessments. If changes are minimal, they may be noted on the initial assessment. All changes must be initialed and dated by the worker. The term "Reassessment" with the worker's name and date must be noted on the front of the UAI to indicate that it has been used for this purpose. The worker should use his or her professional judgment about when a completed UAI can be used for reassessment purposes. If updating a previously completed form would be confusing, a new UAI should be initiated for the reassessment. When using the UAI in ASAPs, follow the instructions in the User's Manual for placing a copy of the UAI in "History" and revising the current UAI.
- 3.2.9** DMAS will reimburse for any completed nursing facility preadmission screening or ALF assessment that was completed in good faith, regardless of whether or not the adult assessed meets eligibility requirements or accesses services. The financial eligibility determination and the functional assessment using the UAI are two separate processes and should be completed simultaneously.
- 3.2.10** For ALF assessments and reassessments and nursing facility preadmission screenings, the original UAI should follow the resident.

3.3. Required Assessment Areas

Assessments must be performed in all of the five following areas for all adult services cases. Completion of the UAI meets this requirement. Additional assessments may be necessary as determined by the worker.

3.3.1 Physical Environment (Section 1 of UAI)

An assessment of the adult's physical environment provides information about safety and health risks. When assessing the physical environment, the worker should consider:

- 1) An evaluation of the dwelling for structural soundness, safety hazards, utilities, cleanliness, and barriers to mobility or use.
- 2) Identification of type and feasibility of needed improvements or changes to the adult's environment.

3.3.2 Functional Status (Section 2 of UAI)

An assessment of the adult's ability to manage activities of daily living (ADLs) and instrumental ADLs (IADLs) must be made when assessing an adult's need for services. Some areas to consider when assessing functional capacity include:

- 1) The physical, emotional, and cognitive status of the adult, assessing how well he or she performs the various ADL tasks including bathing, dressing, eating/feeding, toileting, transferring in and out of a bed or chair, and maintaining continence.
- 2) The physical, emotional, and cognitive status of the adult, assessing how well he or she performs the various IADL tasks which include meal preparation, housework, laundry, shopping, transportation, money management, using the telephone, and/or home maintenance.

3.3.3 Physical Health Assessment (Section 3 of the UAI)

The assessment of physical health may be based on reports of illness, disabilities, and symptoms from the adult, the adult's friends or family members, the adult's physician with an authorized release of information, other contacts or records, or based on worker observations. Some areas to consider when assessing physical health include:

- 1) The adult's current medical condition, including any diagnosis or prognosis available, and any services being used.
- 2) Symptoms observed by the worker that may not have been diagnosed or treated.

- 3) The number and type of medication(s) the adult is currently taking (prescription and non-prescription) and whether medication is being prescribed by multiple physicians. (Note: the worker may ask to see medication containers to get more accurate information.)
- 4) Diet and eating habits (nutrition).
- 5) The adult's general appearance and whether it is consistent with the adult's circumstances and environment.
- 6) The adult's need for assistive devices (e.g., eyeglasses, hearing aids, dentures, mobility aid to compensate for physical impairments, etc.).

3.3.4 Psychosocial (Mental Health) Assessment (Section 4 of the UAI)

The worker's assessment of an adult's psychological functioning cannot take the place of a formal clinical evaluation. However, the worker's findings may suggest that a psychiatric problem is present and contributing to the adult's need for services. This assessment can also provide the worker with documentation for recommending a more complete assessment by health professionals to rule out organic and/or physical causes of psychological symptoms. Some areas to consider when assessing psychosocial status include:

- 1) Evidence that the adult is lonely, isolated, or lacking stimulation.
- 2) The adult's perceived emotional or behavioral problem(s).
- 3) Any manifestations of emotional, mental, or behavioral problems (e.g., insomnia, nightmares, crying spells, depression, agitation, unusual fears, thoughts, or perceptions, delusions, hallucinations, etc.).
- 4) Any major life change/crisis in the past year (e.g., death of a significant person, divorce, loss of income, a move, an illness, institutional placement, etc.).
- 5) A suspected untreated mental illness where the adult likely needs, but is not receiving, psychotropic medications or other appropriate treatment.
- 6) Use of any psychotropic medication(s), who prescribed them, and for what purpose.

- 7) The adult's orientation to person, place, and time as well as memory and judgment capacity.

3.3.5 Support Systems (Sections 1, 4, and 5 of the UAI)

The support systems assessment includes an assessment of the adult's family and community support system. It is important that the worker identify those family, friends, neighbors, faith-based, and other voluntary groups and formal supports that comprise the adult's social network. Some areas to consider when assessing support system(s) include:

- 1) Any strong dynamics among family members/caregiver(s)/ formal support systems as related to the care of the adult.
- 2) Frequency and quality of contacts from informal and formal support systems.
- 3) Social contacts and activities the adult has in the community and changes in the pattern of these contacts.

4. THE SERVICE PLAN

A service plan will be initiated that includes the services to be provided, resources to be used to meet the presenting or immediate problem area(s), and an identification of initial target dates.

4.1. Service Plan Requirements

- 4.1.1 Each open case shall have a clearly identifiable, written service plan. Service plans are not required for case types "ALF Reassessment" and "Guardian Report". The Service Plan Screen in ASAPS must be used. See the ASAPS User Manual for details. The Service Plan may be printed from ASAPS if needed.
- 4.1.2 The details in the service plan will vary according to the adult's situation and will be based on the assessment of the adult's strengths and needs.
- 4.1.3 Within 60 days of the date of eligibility, the service plan must be completed. Service plans are formulated jointly between the adult and the service worker as well as the adult's family, when appropriate. All service plans shall have the following information with headings in outline form: goals, unmet needs, objectives, tasks, and target dates.

4.1.4 The service plan shall address the long-term and short-term needs of the adult. Components of the plan include:

- 1) Goal(s);
- 2) Unmet need(s);
- 3) Objective(s);
- 4) Task(s) (i.e., services to be provided, service-related activities, resources to be used); and
- 5) Target dates for meeting objectives.

4.2. Goals, Unmet Needs, Objectives, Tasks, and Target Dates

4.2.1 Goals

The following are **goals** for Adult Services cases:

- 1) To assist the adult to remain in his or her own home as long as possible provided that this is the most appropriate plan of care.
- 2) To restore or retain the adult's independent functioning to the greatest extent possible.
- 3) To assist in arranging out-of-home placement when that is appropriate and the adult or the guardian consents.

4.2.2 Unmet Needs

An unmet need is an identified need that is not currently being met in a way that assures the safety and welfare of the adult. Unmet needs are identified on the UAI after the completion of the assessment.

4.2.3 Objectives

- 1) Objectives should reflect the consensus of the adult, the adult's family's (where appropriate), and service worker consensus regarding the desired outcome of service delivery. Objectives and services selected should be relevant to the goal.
- 2) Each objective shall state clearly WHAT will happen in order to accomplish the goal(s).

- 3) Objectives should be:
 - a. Identified by the adult or representative and worker to eliminate or diminish identified need(s);
 - b. Supportive of the goal(s) selected;
 - c. Stated in terms of measurable result(s) to be achieved or desired outcome(s);
 - d. As behaviorally specific as possible; and
 - e. Updated as the adult's situation changes.

4.2.4 Tasks

Tasks describe the actual provision of services, identifying HOW to achieve each objective, WHO will be involved in accomplishing each objective, WHERE services will be provided, and WHEN services will be provided. Tasks must be specific and measurable. All providers and their services must be identified in the service plan.

4.2.5 Target Dates

The service plan must include dates for achievement of objectives. These dates should be realistic, and should not exceed the redetermination date on the Case Info screen in ASAPS.

4.2.6 Service Plan: An Example

- 1) Goal: To restore or retain Mr. J's independent functioning to the greatest extent possible.
- 2) Unmet Need: Nutrition.
- 3) Objective: Mr. J. will gain 10 pounds.
- 4) Task: Arrange 5 hours of companion services weekly to prepare lunch and an evening meal.
- 5) Target Date: 3 months from date of plan.

4.2.7 Date Resolved

The Date Resolved will indicate when the objectives are met. If the objective is not achieved by the target date, the reasons should be documented in the "Evaluation of Services" section on the Service Plan in ASAPS.

4.3. Case Type Selection

Each open service case must have a primary "case type" designated. Adult services cases must be opened according to one of the following case type definitions:

- 4.3.1 APS:** The APS report has been investigated and the disposition was "Needs Protective Services and Accepts". Protective services are being provided except there are no home-based care services being provided. Contacts must be made at least monthly with the adult/collateral.
- 4.3.2 APS-Home Based Care:** The APS report has been investigated and the disposition was "Needs Protective Services and Accepts". Home-based care (companion, chore, homemaker) is one of the protective services being provided. The "-Home Based Care" extension was added to make it easier to identify a case with home-based care services within a caseload listing. Contacts must be made at least monthly with the adult/collateral.
- 4.3.3 APS Investigation:** An APS report is being investigated and no disposition has been made. Once a disposition has been made, the case type is changed if the case remains open, or the case is closed.
- 4.3.4 AS:** A case in which intervention is primarily needed to maintain and monitor on-going services to promote self-sufficiency and enhance functioning of the adult. At least a quarterly contact with the adult/collateral must be made.
- 4.3.5 AS – Home Based Care:** A case in which intervention is primarily needed to maintain and monitor on-going services to promote self-sufficiency and enhance functioning of the adult. Home-based care (companion, chore, homemaker) is one of the services being provided. The "-Home Based Care" extension was added to make it easier to identify a case with home-based care services within a caseload listing. At least a quarterly contact with the adult/collateral must be made.
- 4.3.6 AS – Intensive services:** A case in which intervention may be intense and require many resources in an attempt to stabilize the situation. Frequent and planned contacts with the adult/collateral are documented in the service plan. Contacts must be made at least monthly with the adult/collateral.

4.3.7 AS – Intensive services-Home Based Care: A case in which intervention may be intense and require many resources in an attempt to stabilize the situation. Frequent and planned contacts with the adult/collateral are documented in the service plan. Home-based care (companion, chore, homemaker) is one of the services being provided. The “-Home Based Care” extension was added to make it easier to identify a case with home-based care services within a caseload listing. Contacts must be made at least monthly with the adult/collateral.

4.3.8 ALF Reassessment: A case in which the only service being provided is the annual reassessment of the adult in an ALF that is required to maintain eligibility for AG. The case is opened and the redetermination date is the date the reassessment is due.

4.3.9 Guardian Report: A case in which the only service being provided is the receipt and review of the Annual Report of the Guardian that is required by the Code of Virginia, § 37.2-1022. The case is opened and the redetermination date is the date the initial or annual report is due.

4.4. Resource Appraisal and Selection

The adult may require a service provider outside of the local department. Below are Volume VII policy references on resources:

Long-Term Care Services	Section IV, Chapter D
Intake and Case Management	Section I, Chapter B
Adult Services Providers	Section IV, Chapter E
Purchase of Services	Section I, Chapter G

4.5. Service Delivery

Social services shall be provided directly, by referral, or by purchase as required in order to assure appropriate service delivery and resource utilization necessary for implementation of the service plan.

4.5.1 Direct Services

Direct services are those services provided, arranged, monitored, and/or referred by the local department staff as outlined in the service plan. Case management is an inherent part of the provision of direct services.

4.5.2 Referrals

Referrals are made when the worker directs the adult to an outside source for assistance.

4.5.3 Purchased Services

Purchased services are those services purchased for adults by local departments from approved providers, including department-approved providers and providers with whom the local department contracts.

4.5.4 On-Going Service Planning and Delivery

Following the initiation of the service plan, the assessment is to continue on a mutual basis between the adult and worker in order to document further service needs as a basis for the setting of long-range service objectives, the selection of services to fulfill those objectives, and the choices of resources to be used. In addition, the worker must follow all appropriate generic policy in Volume VII, Section I.

4.5.5 Waiting Lists/Fees-for-Services

See Volume VII, Section I, Chapter B, Intake and Case Management, for information on waiting lists and fees-for-services.

4.6. Required Contacts

For case types AS-Intensive Services, AS-Intensive Services-Home Based Care, APS and APS-Home Based Care, contacts (face-to-face or by telephone) must be made at least monthly. More frequent contacts may be needed depending on the case situation. For case types AS, and AS-Home Based Care, contacts with the adult (face-to-face or by telephone) are required at least every three months (quarterly) for the purpose of determining the adult's progress toward achieving objectives stated in the service plan. For case types Guardian Report and ALF Reassessment, quarterly contacts are not required.

For adult services and adult protective services, contact includes communication with the adult or a legally appointed guardian. More frequent contact should occur as needed. The worker should verify by observation or personal interview that the adult is receiving the planned services and to identify any changes in the adult's situation. The worker must make timely, regular contacts with providers to monitor the provision of services and the well-being of the adult. All contacts should be documented in the case narrative.

4.7. Reassessment/Evaluation of Service Delivery

The adult and the service worker shall conduct, collaboratively, an evaluation of progress towards meeting the goals and objectives and the delivery of services at the time of any completion or termination of a service or at other times as deemed appropriate, not to exceed the time standards for case reviews and redetermination. See Volume VII, Section I, Chapter B, Intake and Case Management, for related policy.

The social worker must reassess a case when there is significant change in the adult's circumstances, but no less than once every 12 months. A significant change in an adult's condition occurs when the change is expected to last more than 30 days or appears to warrant a change in the adult's service plan or level of care. The reassessment must include an updated UAI and a brief summary evaluation of the effectiveness of service delivery and an update of the service plan as appropriate. If the original assessment was conducted on the UAI, the worker may use that same assessment for reassessment purposes by clearly noting any changes on the UAI. The worker must initial and date these changes. When using the UAI in ASAPS, follow the instructions in the ASAPS User's Manual for placing a copy of the UAI in "History" and revising the current UAI.

The evaluation of service delivery must address the effectiveness of the service plan in meeting the goals and objectives of the adult and the worker. The evaluation must indicate whether target dates were met or modified and why and must report the outcome of the social worker's service provision. The evaluation of the service delivery must be documented in the "Evaluation of Service" section in the Service Plan in ASAPS.

Based on the UAI reassessment, the worker must document:

- 1) The effectiveness of the service plan; the service plan must be updated, if necessary.
- 2) A description of the adult's current situation with input from the adult and family, if applicable, to determine if there are needs which should be addressed.
- 3) An indication of whether additional services are needed. If so, the service plan must be revised accordingly. If no further services are needed, the case should be closed.

5. CLOSURE OF AN ADULT SERVICES CASE

5.1. When an Adult Services Case May Be Closed

An Adult Services case may be closed under any one of the following circumstances:

- 5.1.1** The service plan goals and objectives have been met.
- 5.1.2** Services are no longer needed.
- 5.1.3** The adult requests closure, and, in the worker's professional judgment, the adult has the capacity to make that decision.
- 5.1.4** The capable adult fails to follow the mutually agreed upon service plan, and the case record documents repeated attempts by worker to implement the plan.
- 5.1.5** The local department is no longer able to serve the adult, and the adult is not a required population to be served.
- 5.1.6** The local department is not able to maintain contact with the adult at least every quarter because the adult cannot be located or is not available.
- 5.1.7** The adult relocates to another jurisdiction. Placement in a long-term care facility may be considered a "relocation."
- 5.1.8** The adult dies.

5.2. Relocation

- 5.2.1** When the relocation is permanent, the adult will be considered a resident of the new locality. The local department previously providing services closes the case. The case is opened by the local department serving the locality where the adult resides.
- 5.2.2** When a planned relocation is expected to be permanent, and the adult will need services in the new jurisdiction, the local departments involved should assist each other in the placement. If services will be needed, the sending local department should:
 - 1)** Notify the receiving local department of the expected date of the placement, the facility selected, and the services needed;
 - 2)** If only ALF Reassessment is needed, the sending department must notify the receiving department of the admission date and the name of the facility;
 - 3)** Offer to assist in completing an application if needed;

- 4) If the adult requests, send a copy of the record and a brief summary to the receiving local department before the adult arrives.
- 5) For case type Guardian Report follow the procedures in Volume VII, Section IV, Chapter B, Appendix G (Protecting Vulnerable Adults through Guardianship and/or Conservatorship).

5.3. Notice of Action

Proper procedures regarding notice to the adult and documentation must be followed when closing a case. See Volume VII, Section I, Chapter B, Intake and Case Management, for information.

APPENDIX A: EXPENDITURES FOR SERVICES

1. Funding Allocations

Each local department receives funding to purchase services needed by an adult to meet the goals of the adult's service plan. Local departments are encouraged to make maximum use of this funding in providing services to adults and must be aware of the number of cases their allocations will support throughout the year. During the course of the fiscal year, if the local department realizes that it has been allocated more funds than are needed to serve its adults, the local department should return the surplus funds in a timely manner to the state for reallocation to other local departments. Local departments should make an effort to spend all of their funding for necessary services for the elderly and impaired adults in their communities.

2. Reimbursement to Localities for Adult Services

The Division of Finance utilizes an automated system referred to as LASER (Locality Automated System for Expenditure Reimbursement) to process local department expenditures for the purpose of providing reimbursement from VDSS.

3. Budget Lines, Cost Codes, and Descriptions used by Adult Services

Below are descriptions regarding services that local departments provide as Adult Services. Not all agencies offer all of these programs.

21704 GUARDIANSHIP PETITIONS

Provides for the costs of petitioning the court for appointment of a guardian for a Medicaid applicant who is unable to apply for himself/herself.

NOTE: VDSS does not provide a local budget allocation for this cost code - all expenditures entered in 21704 will be funded using 50% federal and 50% state funds.

Localities should complete the form, Reimbursable Costs of Guardianship Proceedings, found in the Adult Protective Services Manual, Volume VII, Section IV, Chapter B, Appendix R-2. Expenses must be itemized, attached to the form, and retained in the locality as documentation for reimbursement.

Reimbursable Examples

- Expenses occurred during a guardianship proceeding for a Medicaid applicant who is unable to apply for himself/herself:
 - Evaluation
 - Guardian ad litem legal fees
 - Attorney legal fees
 - Court filing fees
 - Other costs (itemized)

Nursing Facility Preadmission Screening

Individuals who are Medicaid eligible or will be Medicaid eligible within 180 days of placement and who are seeking Medicaid coverage for nursing facility care must be screened to determine their need for the service (*Code of Virginia*, §32.1-330). References the *Virginia Medicaid Nursing Home Preadmission Screening Manual* for details on procedures. *DMAS will be paying for Medicaid pre-admission screenings through the RMS process.*

The reimbursement for the following processes are not made through LASER, but directly by DMAS through First Health to the LDSS.

Assisted Living Facilities - Initial Full Assessment

Local departments assess Auxiliary Grant (AG) recipients using the Virginia UAI to determine the level of care required in an assisted living facility (ALF). The local department providing the assessment will be reimbursed at the initial assessment rate for a full assessment. See the *Virginia Assisted Living Facility Assessment Manual* for details on procedures. Payments to localities are made directly by DMAS to the LDSS.

Assisted Living Facilities- Initial Short Assessment

Local departments assess AG recipients using the Virginia UAI to determine the level of care required in an ALF. The local department providing the assessment will be reimbursed at the initial assessment rate for a full assessment. Payments to localities are made directly by DMAS to the LDSS.

Assisted Living Facilities – Annual Reassessments

Local departments reassess AG recipients annually to determine if the adult continues to meet the level of care that is required in an ALF. See the *Virginia Assisted Living Facility Assessment Manual* for details on procedures. Payments to localities are made directly by DMAS to the LDSS.

ADULT SERVICES (833) AND OTHER PURCHASED SERVICES (824)**83304 Adult Services- Home-Based Companion (State Supplement)/
82423 Home-Based Care-Companion (Block Grant)**

Companion services are performed by an individual or a department provider who assists adults unable to care for themselves without assistance and where there is no one available to provide the needed services without cost. Services may include dressing, bathing, toileting, feeding, household and financial management, meal preparation, and shopping. Companion services shall only be provided to an eligible adult who lives in his or her own home. After all funds are expended in Cost Code 83304, Cost Code 82423 may be utilized.

**83301 Adult Services – Home-Based Care -- Chore (State Supplement)/
82414 Home-Based Care – Chore (Block Grant)**

Chore services are the performance of non-routine, heavy home maintenance for

adults unable to perform such tasks themselves. Chore services are provided only to adults living in an independent situation who are responsible for maintenance of their own home or apartment and have no one available to provide this service without cost. Chore services include yard maintenance, painting, chopping wood, carrying wood and water, snow removal, and minor repair work in the home. After all funds are expended in 83301, Cost Code 82414 may be utilized.

**83303 Adult Services – Home-Based Homemaker (State Supplement)/
82422 Home-Based Care – Homemaker (Block Grant)**

Homemaker services are provided by an individual or agency provider who gives instruction in, or where appropriate, performs activities to maintain a household. The activities may include personal care, home management, household maintenance, nutrition, consumer education, and hygiene education. After all funds are expended in Cost Code 83303, Cost Code 82422 may be utilized.

83302/82404 Adult Day Services

Program funds are used to purchase adult day services from approved/licensed providers for a portion of a 24-hour day. Adult day services assess the needs of participants and offer services to meet those needs. Participants attend on a planned basis. Services include: personal supervision of the adult and activities that promote physical and emotional well-being through socialization. After all funds are expended in 83302, Cost Code 82404 may be utilized.

82412 Foster Care for Adults

This includes the purchase of room and board, supervision and special services in an approved foster home for an adult who has a physical/mental health condition or emotional/behavioral problem. The adult must be incapable of independent living or unable to remain in his or her own home.

82417 Nutrition-related Services

This includes the purchase of education about daily nutritional needs and purchase of home-delivered meals and congregate meals. An adult is not considered to be in need of home-delivered or congregate meals if his or her meals are provided in a nursing home, institution, ALF, or room and board situation or as a member of a family. An adult is not considered to be in need if his or her only cost is for purchasing raw food, and he or she has someone to prepare the meals at no charge.

ADULT PROTECTIVE SERVICES (895)

This budget line is used to fund the APS program. This funding may be used for reimbursable expenses or for administration of the APS program. A base amount is provided to each locality. Additional APS funding is distributed using a need-based formula.

89501 Adult Protective Services

82401 Adult Protective Services (Block Grant)

Protective services to adults consist of the receipt and thorough investigation of reports of abuse, neglect or exploitation of adults and of reports that adults are at risk of abuse, neglect or exploitation. APS provides services to elders and to incapacitated adults. Purchase of services are appropriate under the following circumstances: 1) an APS report has been taken and the investigation has determined that an elder or an incapacitated adult needs protective services and the service to be purchased is part of the service plan to protect the adult from ongoing abuse, neglect or exploitation; or 2) an APS report has been taken and the protective services investigation has found an elder or an incapacitated adult to be at risk of abuse, neglect or exploitation and the service to be purchased is part of the service plan to prevent abuse, neglect or exploitation from occurring.

Adult Protective Services may also be purchased for an adult using budget line 824 (Other Purchased Services).

Admin Adult Protective Services

Administrative costs of operating the APS program are included in Services Staff and Operations or Services Staff and Operations Pass-Thru (budget lines 854 and 857). Reimbursable examples include on-call coverage for staff who provide coverage for APS on nights, holidays, weekends, and other times outside of regular office hours; costs of staff travel for investigating, for ongoing service delivery, for training/education purposes, or other travel costs related to the APS program; office supplies and equipment dedicated to the operation of the APS program; and costs of community outreach to increase awareness of the problem of adult abuse.

89503 Adult Protective Services-Guardianship Fees

Section 37.2-1021 of the Code of Virginia requires an annual personal status report on the incapacitated adult for whom a guardian has been appointed, the Annual Report of Guardian for an Incapacitated Person Form (Form CC-1644). Section 37.2-1021 requires that guardians complete this form and submit it annually to the LDSS in the jurisdiction where the incapacitated adult lives. Section 37.2-1021 requires that the annual report, when filed, be accompanied by a filing fee of five dollars. Checks for filing fees should be made payable to the local department of social services.

Section 37.2-1021 requires that the \$5 filing fee that accompanies annual guardianship reports be retained by the LDSS in the jurisdiction where the fee is collected and be used in the provision of services to protect vulnerable adults and prevent abuse, neglect or exploitation of vulnerable adults.

Enter the receipt of fees paid to the locality using expenditure type "R" (receipt) as a credit to account number 40895, Receipt of Fees, using the non-reimbursable fund code 0099. Local departments should use funds in this cost code for services to adults in the same manner that funds are used in 89501 for services to vulnerable adults served through the APS program.